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No. 10-1045

In the
Supreme Court of the United States

JANIS L. BROWN, INDIVIDUALLY AND AS PERSONAL REPRESENTATIVE OF THE ESTATE OF JASON RAY BROWN, DECEASED, ET AL.,

Petitioners,

v.

THOMAS J. CALLAHAN, INDIVIDUALLY AND IN HIS OFFICIAL CAPACITY AS SHERIFF, WICHITA COUNTY, TEXAS,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

On October 7, 2010, after oral argument, the United States Court of Appeals for the Fifth Circuit ("the Fifth Circuit") determined that Sheriff Callahan is entitled to qualified immunity, thereby reversing a previous decision of the United States District Court for the Northern District of Texas. The present Petition for a Writ of Certiorari followed.

Three questions are presented:

1. Whether the Fifth Circuit erred in determining that the undisputed evidence shows that no causal link connects Jason Brown's ("Brown") death to any action or inaction by Sheriff Callahan, including the "unlawful medical care" of which Petitioners complain.

2. Whether the Fifth Circuit erred in finding that well-settled law applied to the undisputed evidence required a conclusion that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his training and/or supervision of Dr. Bolin and the jail nurses.

3. Whether the Fifth Circuit erred in finding that well-settled law applied to the undisputed evidence required a conclusion that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his adoption of jail policies or procedures.

LIST OF PARITES

Pursuant to Supreme Court Rule 24(b), Sheriff Callahan provides the following list of parties to the proceeding in the Court whose judgment is under review:

1. Janis L. Brown, Individually, and as Personal Representative of the Estate of Jason Ray Brown, Deceased; Petitioner;

2. Billy Ray Brown; Petitioner;

3. Thomas J. Callahan, Sheriff of Wichita County, Texas, in his Individual and Official Capacity; Respondent.

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The opinion of the Fifth Circuit which Petitioners challenge was reported at 623 F.3d 248 (5th Cir. 2010). The opinion of the United States District Court for the Northern District of Texas, Wichita Falls Division, was not selected for publication in the Federal Supplement Reporter.

STATEMENT OF JURISDICTION

The Fifth Circuit entered the decision of which Petitioners complain on October 7, 2010, and Petitioner's Motion for Rehearing wad denied on November 18, 2010. Judgment issued as mandate to the District Court on December 6, 2010. Because judgment has been rendered in this case, this Court has jurisdiction over Petitioner's Petition for Writ of Certiorari. 28 U.S.C. § 1254(1).

RELEVANT LEGAL AUTHORITIES

Pursuant to Supreme Court Rule 24(f), Sheriff Callahan provides the following references to the legal authorities relevant to the present Petition for Writ of Certiorari:

42 U.S.C. § 1983:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the

> Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

United States Constitution, Amendment XIV, § 1

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATEMENT OF THE CASE

A. The Events Giving Rise to This Appeal

On or about July 22, 2004, Brown was arrested in Burkburnett, Texas, and was transported to the Wichita County Jail ("the Jail") at approximately 4:00 p.m. On the evening of July 23, 2004, at approximately 11:42 p.m., inmates in tank 7/6 called the control room by using the emergency call button

and notified the control room operator that Brown had thrown up blood on the floor. (USCA5, Vol. 10, Jt. App. 162.) Deputies Greene and Sours responded to the inmates' call. (USCA5, Vol. 10, Jt. App. 162, 170.) When they arrived, Deputies Greene and Sours saw a puddle of vomit on the floor near the back of the tank. (USCA5, Vol. 10, Jt. App. 162, 170.) Although they described the vomit as blood in their statements, Deputies Greene and Sours referred to the vomit as "blood" because the inmates reported it as such when they called the control room to report the incident. Deputies Greene and Sours did not know if the vomit actually contained any blood and are not qualified to make such a determination due to their lack of medical training. Deputy Greene recalls the puddle of vomit covering approximately 14 by 16 inches of the floor of the cell. (USCA5, Vol. 10, Jt. App. 170.)

Deputy Sours then had a discussion with Brown regarding medications he was taking and possible causes for his condition. After the conversation with Brown, Deputies Greene and Sours asked the control room officer to call Nurse Kaye Krajca to advise her of the situation. (USCA5, Vol. 10, Jt. App. 162, 170, 183.) Nurse Krajca instructed the control room officers to give Brown liquid antacid. (USCA5, Vol. 10, Jt. App. 162, 170.) Deputy Greene gave Brown the antacid, and he and Deputy Sours left the tank. (USCA5, Vol. 10, Jt. App. 162, 170.)

Later, an inmate in Tank 7/6 pushed the emergency call button again to contact the control room and reported that Brown was complaining of pain. (USCA5, Vol. 10, Jt. App. 162, 170.) Upon receiving the complaint, Nurse Krajca was called once again and recommended that Brown be given suppositories.

(USCA5, Vol. 10, Jt. App. 162, 170-71.) Deputy Sours then proceeded to the control room and called Nurse Krajca regarding Brown's condition. (USCA5, Vol. 10, Jt. App. 162, 170.) At approximately 2:25 a.m., Deputies Greene and Sours went into tank 7/6 and offered the suppositories to Brown. (USCA5, Vol. 10, Jt. App. 162, 170-71.) However, Brown refused to take the suppositories. (USCA5, Vol. 10, Jt. App. 162, 171.) Since he would not communicate with them, Nurse Krajca was called back and advised of Brown's condition. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca then proceeded to the tank to examine Brown. (USCA5, Vol. 10, Jt. App. 171, 183.) When she arrived at approximately 2:55 a.m., Nurse Krajca and Deputies Greene and Sours went to tank 7/6. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca tried talking to Brown, and he eventually communicated with her. (USCA5, Vol. 10, Jt. App. 171, 183.) Nurse Krajca told Deputies Greene and Sours to move Brown to medical solitary. (USCA5, Vol. 10, Jt. App. 171, 183.) Brown was placed in medical solitary cell S/3 at 3:12 a.m. (USCA5, Vol. 10, Jt. App. 171, 183.)

Once Brown was in medical solitary, Nurse Krajca tried to get Brown to take the suppository. (USCA5, Vol. 10, Jt. App. 162, 171, 183.) Deputies Greene and Sours helped Brown up, and Nurse Krajca administered the suppository. (USCA5, Vol. 10, Jt. App. 162, 171, 183.) They then exited Brown's medical solitary cell. (USCA5, Vol. 10, Jt. App. 162, 171, 183.)

Deputies Greene and Sours checked on Brown throughout the remainder of the shift and observed him sleeping throughout the early morning hours. (USCA5, Vol. 10, Jt. App. 162, 171.) At approximately 5:29 a.m. on July 24, Deputies Greene and Sours fed

the inmates breakfast. (USCA5, Vol. 10, Jt. App. 162, 171.) When they arrived at Brown's solitary cell, they opened the food portal and alerted Brown that his breakfast was served. (USCA5, Vol. 10, Jt. App. 162, 171.) Deputy Sours asked Brown if he wanted to eat and Brown indicated that he did not wish to eat. (USCA5, Vol. 10, Jt. App. 162, 171.) For the remainder of the morning, Deputies Greene and Sours observed Brown sleeping. (USCA5, Vol. 10, Jt. App. 162, 171.) Their shifts ended at 7:00 a.m. (USCA5, Vol. 10, Jt. App. 162, 171.) Deputy Sours observed that at the end of the shift, Brown's condition did not appear to have changed. (USCA5, Vol. 10, Jt. App. 162, 171.)

On July 24, 2004, Deputies Yeager, Dickerman, and Geary worked the 7:00 a.m. to 3:00 p.m. shift and observed Brown numerous times during that time. (USCA5, Vol. 9, Jt. App. 087; Vol. 10, Jt. App. 162, 171.) Deputy Yeager regularly checked on Brown by looking through the window in the door to make sure that he was breathing and his position periodically changed. (USCA5, Vol. 10, Jt. App. 186.) At 10:38 a.m., Deputy Yeager heard Brown making noises while laying on his bunk. (USCA5, Vol. 10, Jt. App. 186.) Deputy Yeager checked on him, and Brown indicated that he was alright. (USCA5, Vol. 10, Jt. App. 186.)

At approximately 11:30 a.m., Deputies Yeager and Dickerman stopped at Brown's cell to serve him lunch. (USCA5, Vol. 9, Jt. App. 87; Vol. 10, p. 186.) When Deputy Dickerman told Brown that the meal had arrived, Brown made several noises. (USCA5, Vol. 9, Jt. App. 87-88.) Deputy Dickerman asked once again if he wanted to eat and Brown turned his head and indicated that he did not want to eat. (USCA5, Vol. 9,

Jt. App. 87-88.) Deputy Yeager was on the other side of the tray cart, preparing to hand Deputy Dickerman a tray for Brown. (USCA5, Vol. 10, Jt. App. 186.) Deputy Yeager did not hear a response, but saw Brown through the serving door move his arm up around his head as if to indicate that he did not want a food tray. (USCA5, Vol. 10, Jt. App. 186.) It is not unusual for inmates to respond in such a manner. (USCA5, Vol. 10, Jt. App. 186.) From that time on Deputy Yeager observed Brown sleeping. (USCA5, Vol. 10, Jt. App. 186.) Specifically, Deputy Yeager observed Brown sleeping at 12:26 p.m., 12:58 p.m., 2:30 p.m. and 2:50 p.m. (USCA5, Vol 9, Jt. App. 90; Vol. 10, Jt. App. 91-119.)

Throughout his shift, Deputy Dickerman observed Brown in different positions and in different stages of dress. (USCA5, Vol. 9, Jt. App. 87-88.) Brown always appeared to be breathing when Deputy Dickerman observed him. (USCA5, Vol. 9, Jt. App. 87-88.) Deputy Dickerman also observed Brown sleeping at 1:35 p.m. and 1:57 p.m. (USCA5, Vol. 9, Jt. App. 87-88.)

Deputies Parish and Whatley worked the second shift from 3:00 to 11:00 p.m. on July 24, 2004. (USCA5, Vol. 10, Jt. App. 188.) At 3:55 p.m., during Deputy Whatley's initial patrols of cells 7/3-7/6 and S/3-S/4, he observed Brown lying on his bunk wearing only a shirt. (USCA5, Vol. 10, Jt. App. 188.) Deputy Whatley also observed Brown move. (USCA5, Vol. 10, Jt. App. 188.) At mealtime while Deputy Whatley was serving trays, he opened the food compartment on Brown's cell door and told Brown that a meal was being served. (USCA5, Vol. 10, Jt. App. 188.) Brown

indicated that he did not wish to eat his meal. (USCA5, Vol. 10, Jt. App. 188.)

As Deputy Whatley checked Brown later during his shift, he observed that Brown had moved and changed positions. (USCA5, Vol. 10, Jt. App. 188.) Later during his shift, Deputy Whatley observed Brown's chest was rising and falling and believed that Brown was sleeping. (USCA5, Vol. 10, Jt. App. 188.) Deputy Whatley observed Brown's skin coloring several times and it appeared normal and did not seem to change. (USCA5, Vol. 10, Jt. App. 188.) He observed Brown sleeping at 4:00 p.m., 6:00 p.m., 7:00 p.m., 8:00 p.m., 9:03 p.m., 9:26 p.m. and 9:59 p.m. (USCA5, Vol 9, Jt. App. 90; Vol. 10, Jt. App. 91-119.

At approximately 10:00 p.m. on July 24, 2004, Deputy Parish briefly observed Brown when he entered his cell. When Deputy Parish briefly observed Brown, he was asleep on his bunk. Deputy Parish did not notice anything unusual.

Later in the evening of July 24, 2004, Deputy Greene returned to the jail and worked the third shift, which began at 11:00 p.m. (USCA5, Vol. 10, Jt. App. 171.) At approximately 11:30 p.m., Deputy Ryan called Deputy Greene and asked him to come to Brown's medical solitary cell to assist with checking on Brown. (USCA5, Vol. 10, Jt. App. 190.) Upon entering Brown's cell, Deputy Greene tried unsuccessfully to get Brown to speak to him and gently shook him on the shoulder. (USCA5, Vol. 10, Jt. App. 190.) When Brown did not respond, Deputy Greene tried to find a pulse on Brown's wrist, but was unable to do so. (USCA5, Vol. 10, Jt. App. 190.) Deputy Greene and Officer Ryan immediately went to the control room to

advise Lt. Enoch of their findings, and Lt. Enoch then called for emergency assistance. (USCA5, Vol. 10, Jt. App. 190.) Deputies Greene and Ryan returned to Brown's cell and covered Brown from the waist down with a blanket. (USCA5, Vol. 10, Jt. App. 190.) An autopsy of Brown's body later revealed that he had suffered from a gastrointestinal hemorrhage due to rupture of the esophageal varicies caused by chronic viral hepatitis with cirrhosis of the liver. (USCA5, Vol. 10, Jt. App. 190.)

B. Sheriff Callahan's Policies Regarding Healthcare in the Jail

Sheriff Callahan has been the Wichita County Sheriff since being elected in 1986. (USCA5, Vol. 9, Jt. App. 33.) During his twenty-three year tenure as Wichita County Sheriff, Wichita County has always had a policy of providing reasonable medical care to pretrial detainees and of not violating the constitutional rights of inmates housed in the Jail. (USCA5, Vol. 9, Jt. App. 33.) Additionally, while he has been sheriff, the Wichita County Sheriff's Department has not had a policy of being deliberately indifferent to the serious medical needs of its inmates. (USCA5, Vol. 9, Jt. App. 33.)

Wichita County contracted with a jail physician to oversee the health services plan for the Wichita County Sheriff's Office. (USCA5, Vol. 9, Jt. App. 34.) The Record shows that Sheriff Callahan had no knowledge that Brown was incarcerated in the Jail at any the time relevant to this litigation, he had no contact with Brown while he was in the Jail, no one had any communication with him regarding Brown while he was in the Jail, and gave no instructions or

orders regarding Brown during his incarceration in the Jail. (USCA5, Vol. 9, Jt. App. 34.)

Sheriff Callahan is of the opinion that the Jail physician, Dan Bolin, M.D., is an excellent physician who handles his job as jail physician in a professional and serious manner. (USCA5, Vol. 9, p. 2194.) It was Dr. Bolin's responsibility to supervise the nurses in their professional capacities, while Sheriff Callahan supervised the nurses in their administrative capacities. (USCA5, Vol. 10, p. 2396; Vol. 3, p. 745; Vol. 11, p. 2515.) Additionally, Sheriff Callahan had personally drafted a Health Services Plan which had been approved by the Texas Commission on Jail Standards–the agency which regulates and certifies jails in the State of Texas. (USCA5, Vol. 11, p. 2510, 2514.) The policy, custom and practice of the Wichita County Sheriff's Department relating to health services and medical care is fully set forth in the plan. The Jail facility itself has also been approved by the Texas Commission on Jail Standards. The Health Services Plan can be found in the Record on Appeal at Volume 10, pages 2433 through 2441, and represents Sheriff Callahan's general orders regarding administering health care to inmates confined in the Jail. (USCA5, Vol. 11, p. 2510.) According to the Health Services Plan, Sheriff Callahan ordered the Jail's medical staff to immediately transport inmates to the hospital in case of emergency medical situations. (USCA5, Vol. 11, p. 2438.) The Health Services Plan specifically gives the authority to jail nurses to determine if transportation to the hospital is necessary, and directs jail nurses to order transportation to the hospital in case of emergency medical situations. (*Id.*) Further, Sheriff Callahan instructed the nursing staff to call Dr. Bolin "at any

time they need to." (*Id.*) As mentioned above, Sheriff Callahan instructed the Jail's medical staff to transport seriously ill inmates to the hospital at any time they deemed it necessary, and specifically gave the nursing staff the authority to do so. (USCA5, Vol. 11, p. 2438.)

The medical services plan calls for six full-time nurses to care for inmates in the Jail. (USCA5, Vol. 9, Jt. App. 34.) If there is not a nurse on physically present at the Jail, there is always a nurse on call who is immediately available to detention staff. (USCA5, Vol. 9, Jt. App. 34.) Additionally, Dr. Bolin is always on call if needed by the nurses. (USCA5, Vol. 9, Jt. App. 34.) If Dr. Bolin is out of town or otherwise unavailable, he provides access to another doctor who is immediately available and on call if needed. (USCA5, Vol. 9, Jt. App. 34-35.)

In the year Brown's death occurred, Wichita County spent more than $380,000 in payroll for the medical staff at the Jail. (USCA5, Vol. 9, Jt. App. 35.) In the last ten years, Wichita County has averaged more than $160,000 in expenditures for drugs and other medical supplies that have been used in providing medical services in the Jail to the inmates. (USCA5, Vol. 9, Jt. App. 35.) Further, the ten year average in dental expenses provided to the inmates is approximately $33,000 per year. (USCA5, Vol. 9, Jt. App. 35.) The Wichita County Sheriff's Office does not have to pay for medical services provided by United Regional Health Care Systems, so those expenses are not included in the foregoing figures. (USCA5, Vol. 9, Jt. App. 35.) If an inmate needs emergency medical care due to a condition that is deemed by jail and/or medical staff at the jail to be life threatening, they are

to be transported to United Regional Health Care System's Emergency Room for treatment. (USCA5, Vol. 9, Jt. App. 35.) Common sense is used in determining what constitutes an emergency by the shift supervisor and/or the nursing staff at the jail. (USCA5, Vol. 9, Jt. App. 35.) It is the policy, custom and practice of Wichita County that if there is any question as to the seriousness of the situation, the situation is handled as an emergency, and then a shift supervisor uses his or her best judgment. (USCA5, Vol. 9, Jt. App. 35.)

In short, the Record clearly shows that Brown's death was not a result of any act or inaction of any person working for Wichita County. Additionally, the Record shows that Sheriff Callahan did not have any subjective knowledge that his training and/or supervision and/or policies regarding the Jail would result in any person being denied medical care.

SUMMARY OF THE ARGUMENT

The Record clearly shows that Sheriff Callahan is entitled to qualified immunity from Petitioner's claims. Specifically, there is absolutely no causal connection between Brown's death and any action or inaction by Sheriff Callahan, any policy he implemented, or any training, and/or supervision which he provided. There is no evidence that Sheriff Callahan was deliberately indifferent to any of Brown's or Petitioners' constitutional rights.

ARGUMENT

A. Qualified Immunity Standard

Public officials acting within the scope of their authority are generally shielded from civil liability by the doctrine of qualified immunity. *See Harlow v. Fitzgerald*, 457 U.S. 800, 102 S. Ct. 2727, 73 L. Ed. 2d 396 (1982). "The doctrine of qualified immunity serves to shield a government official from civil liability for damages based upon the performance of discretionary functions." *Cozzo v. Tangipahoa Parish Council-President Gov't*, 279 F.3d 273, 284 (5th Cir. 2002). "The Supreme Court has characterized the doctrine as protecting 'all but the plainly incompetent or those who knowingly violate the law.'" *Id.* (quoting *Malley v. Briggs*, 475 U.S. 335, 341, 106 S. Ct. 1092, 89 L. Ed. 2d 271 (1986)).

In assessing qualified immunity, courts must conduct a bifurcated analysis. *See, e.g., Collins v. Ainsworth*, 382 F.3d 529, 537 (5th Cir. 2004), *cert. denied*, 547 U.S. 1055, 126 S. Ct. 1661, 164 L. Ed. 2d 397 (2006). The qualified immunity analysis is comprised of two parts which may be considered in any order. *Pearson v. Callahan*, --- U.S. ---, 129 S. Ct. 808, 818, 172 L. Ed. 2d 565 (2009). The initial inquiry asks whether, taken in the light most favorable to the party asserting the injury, the facts alleged show that the official's conduct violated a constitutional right. *See Scott v. Harris*, 550 U.S. 372, 377, 127 S. Ct. 1769, 1774, 167 L. Ed. 2d 686 (2007). "If, and only if, the court finds a violation of a constitutional right, 'the next, sequential step is to ask whether the right was clearly established ... in light of the specific context of the case.'" *Id.* To be clearly established for purposes

of qualified immunity, the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right. *Pearson*, --- U.S. ---, 129 S. Ct. at 815. The unlawfulness of the defendant's actions must have been readily apparent from sufficiently similar situations, but it is not necessary that the defendant's exact act have been held illegal. *Id.*

If the defendant's actions violated a clearly established constitutional right, the corresponding prong of the analysis determines whether qualified immunity is appropriate, nevertheless, because the defendant's actions were objectively reasonable in light of law which was clearly established at the time of the disputed action. *Malley*, 475 U.S. at 341, 106 S. Ct. 1092. An official's conduct is objectively reasonable unless all reasonable officials would have realized the particular challenged conduct violated the constitutional provisions sued on. *Anderson v. Creighton*, 483 U.S. 635, 637-38, 107 S. Ct. 3034, 97 L. Ed. 2d 523 (1987)). A plaintiff must allege sufficient facts to demonstrate that no reasonable officer could have believed his actions were proper. *Id.* Whether an official's conduct was objectively reasonable is a question of law for the court, not a matter for the jury.

The usual summary judgment burden of proof is altered in the case of a qualified immunity defense. *Saldana v. Garza*, 684 F.2d 1159, 1163, n. 14 (5th Cir. 1982), *cert. denied*, 460 U.S. 1012, 103 S. Ct. 1253, 75 L. Ed. 2d 481 (1981). Once an official pleads his good faith, the burden then shifts to the plaintiff, who must rebut the defense by establishing that the official's allegedly wrongful conduct violated clearly established law. *Id.* The plaintiff bears the burden of negating

qualified immunity and cannot rest on conclusory allegations and assertions, but must demonstrate genuine issues of material fact regarding the reasonableness of the official's conduct. *Id.*

B. Sheriff Callahan did not exercise deliberate indifference with respect to the training and/or supervision of the nurses or Dr. Bolin, and he is therefore entitled to qualified immunity.

Respondeat superior liability may not be imposed upon supervisors in an action based on Section 1983. *City of Canton v. Harris*, 489 U.S. 378, 385, 109 S. Ct. 1197, 103 L. Ed. 2d 412 (1978). A plaintiff can only succeed on a failure to train claim by demonstrating that an official's failure to train caused a deprivation of plaintiff's rights and the official's failure to train under the circumstances constituted deliberate indifference. *Thompson v. Upshur Cnty.*, 245 F.3d 447, 459 (5th Cir. 2001). "Deliberate indifference is a stringent standard of fault, requiring proof that a municipal actor disregarded a known or obvious consequence of his action." *Bd. of Cnty. Comm'rs of Bryan Cnty., Okla. v. Brown*, 520 U.S. 397, 410, 117 S. Ct. 1382, 1391, 137 L. Ed. 2d 626 (1997). Indeed, "[d]eliberate indifference is an extremely high standard to meet." *Gobert v. Caldwell*, 463 F.3d 339, 346 (5th Cir. 2006). A supervisory defendant "must know about the conduct and facilitate it, approve it, condone it, or turn a blind eye for fear of what they might see. They must in other words act either knowingly or with deliberate, reckless indifference." *Gonzalez v. Ysleta Indep. Sch. Dist.*, 996 F.2d 745, 761 (5th Cir. 1993). To be deliberately indifferent, "the official must both be aware of facts from which the

inference could be drawn that a substantial risk of harm exists, and he must also draw the inference." *Farmer v. Brennan*, 511 U.S. 825, 837, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994); *see also Wilson v. Seiter*, 501 U.S. 294, 111 S. Ct. 2321, 115 L. Ed. 21d 271 (1991). Mere negligence—and even gross negligence—is insufficient to show that a supervisor exercised deliberate indifference. *City of Canton*, 489 U.S. at 388, 109 S. Ct. 1197.

In the present case, Petitioner attempts to argue that the Court should impose individual liability upon Sheriff Callahan based upon the allegation that "Nurse Krajca perform[ed] duties outside the Texas Nurse Practices Act and Texas and Texas law for prescribing medications [which was] . . . causally related to the death of [Brown]." (Pet. For Writ of Cert., pp. 13-14.) Although Petitioners attempt to couch this argument in a novel manner, Petitioners essentially argue that the nurses were improperly supervised. It is important to note that there is absolutely no evidence in the Record which would support Petitioner's allegation that any medications administered to Brown contributed to his death. Conspicuously, Petitioner does not direct the Court to any legal authority which would support the novel argument that a nurse allegedly practicing outside a medical standard of care could subject a county sheriff to individual liability under Section 1983. At most, such a practice would amount to mere negligence rather than deliberate indifference, and would not meet the extremely high burden of showing that a governmental official acted with deliberate indifference. *See City of Canton*, 489 U.S. at 388, 109 S. Ct. 1197.

Further, deliberate indifference requires a plaintiff to show a pattern of violations of constitutional rights. *Estate of Davis v. City of N. Richland Hills*, 406 F.3d 375, 381 (5th Cir. 2005). Petitioner "respectfully disagree[s]" with this well-settled requirement and argues that this case should fall within the extremely narrow exception to this widely-applied rule which was carved out in *Oklahoma City v. Tuttle*, 471 U.S. 808, 105 S. Ct. 2427, 85 L. Ed. 2d 791 (1985). In *Tuttle*, this Court held that a single event could create liability under Section 1983 under a specific set of very narrow circumstances. This Court further discussed the narrow parameters of *Tuttle* in *Connick v. Thompson*, —U.S.—, —S. Ct.—, —L. Ed. 2d—, 2011 WL 1119022 (March 29, 2011). In *Connick*, *supra*, this Court was confronted with a particularly difficult factual situation wherein a man who had been confined on the Louisiana Death Row for fourteen years was exonerated after it was revealed that the Orleans Parish District Attorney's office had purposely secreted exculpatory evidence in violation of the strictures of *Brady v. Maryland*, 373 U.S. 83, 83 S. Ct. 1194, 10 L. Ed. 2d 215 (1963). *Id.* at *4. After Plaintiff was exonerated of a robbery and found not guilty of a murder, he sued the District Attorney's Office claiming that the *Brady* violation was caused by the Office's unconstitutional policy and resulted from the Office's deliberate indifference to an obvious need to train prosecutors in order to avoid constitutional violations. *Id.*

This Court began its analysis by recognizing that a plaintiff alleging that a municipality is liable for failure to train has the burden of proving both: (1) that the municipality and/or its policymaker was deliberately indifferent to the need to train; and (2)

that the lack of training actually caused the constitutional violation. *Id.* at *6. District Attorney Connick argued that the municipality was entitled to judgment as a matter of law because the plaintiff failed to prove that he was on actual or constructive notice of, and therefore deliberately indifferent to, a need for more or different training. *Id.* The majority of the Court agreed with District Attorney Connick's argument.

This Court held that "[a] pattern of similar constitutional violations by untrained employees is 'ordinarily necessary' to demonstrate deliberate indifference. . . ." *Id.* at *8. "Without notice that a course of training is deficient in a particular respect, decisionmakers can hardly be said to have deliberately chosen a training program that will cause violations of constitutional rights." *Id.* The Court went on to hold that the lack of a pattern of similar violations in the past by the Orleans Parish District Attorney's Office prevented the imposition of supervisory liability in *Connick*. *Id.*

This Court discounted the plaintiff's argument that the case fit into the "narrow range of circumstances" wherein a pattern of violations is not necessary to show deliberate indifference. *Id.* The Court discussed the fact that *City of Canton* recognizes the hypothetical possibility, "however rare," that the "unconstitutional consequences of failing to train could be so patently obvious" that a municipality could be held liable without proof of a pre-existing pattern of violations. *Id.* The "narrow range of *Canton's* single-incident liability" was limited to occasions when officials were required to make "split-second decisions with life-or-death consequences," and wherein officers are

unfamiliar with applicable standards. *Id.* The Court held that the duties of the attorneys considering *Brady* evidence simply do not fit into the "narrow range" of the *City of Canton* exception. *Id.* Indeed, the training which attorneys receive sets them apart from the untrained, heavily-armed officers contemplated in the *City of Canton* hypothetical, and the very narrow exception did not apply. *Id.* As noted in *City of Canton*, "in virtually every instance where a person has had his or her constitutional rights violated by a city employee, a § 1983 plaintiff will be able to point to something the city 'could have done' to prevent the unfortunate incident," but the result of the training in *Connick* was not so predictable that failing to provide the training would have amounted to a conscious disregard of constitutional rights. *Id.* at *10.

According to *Connick*, therefore, the circumstances which would permit a finding of liability based on an isolated incident are not present in this case. Even if Plaintiff's allegations that the nurses acted outside the boundaries of their professional obligations were true, such acts would not qualify the present case for the *Tuttle* exception. Because there is no evidence in the Record of a pattern of deliberate indifference to the serious medical needs of inmates which would subject Sheriff Callahan to individual liability, and this case clearly falls outside of the extremely narrow *Tuttle* exception, Sheriff Callahan respectfully requests that the Court deny Petitioner's request for a Writ of Certiorari.

Plaintiff's arguments regarding Sheriff Callahan's supervision and training of the nurses and Dr. Bolin must also fail because there is no evidence that Sheriff Callahan either failed to supervise or train Dr. Bolin

or the nurses. The Record shows that Dr. Bolin and Wichita County entered into an employment contract to which Callahan is not a signatory. The Contract provides, among other things, that Dr. Bolin will supervise jail nursing staff in their professional capacities. (USCA5 p. 3052.) Further, Sheriff Callahan testified in his deposition that Dr. Bolin was responsible for supervising the nurses' provision of medical care to the inmates. (USCA5 p. 3051-3052.) Since Sheriff Callahan was not responsible for training or supervision of the nurses, he cannot now be held liable for any alleged constitutional violation which may have resulted from such failure. *See Gates v. Tex. Dep't of Prot. & Regulatory Servs.*, 537 F.3d 404, 435 (5th Cir. 2008) (holding that a supervisor was not responsible for failure to train absent an affirmative showing that the supervisor was personally responsible for such inadequacies).

Further, Sheriff Callahan is entitled to qualified immunity because no causal link exists between the alleged failure to train or supervise and the alleged violation of Petitioners' rights since Sheriff Callahan did not have a duty to train and/or supervise the medical care provided by the nurses. (USCA5, Vol. 9, Jt. App. P. 34; p. 3052.) Rather, Dr. Bolin was contractually obligated to provide such training and supervision. (USCA5, p.3052.) Since Dr. Bolin was contractually responsible for training and supervision of the professional activities of the nurses, Sheriff Callahan cannot be held liable for any such failure. If such a failure occurred, then such failure was not Sheriff Callahan's responsibility and Sheriff Callahan is therefore entitled to qualified immunity for any such claims.

Additionally, there is no evidence that Sheriff Callahan ever acted with deliberate indifference, and he is therefore entitled to qualified immunity from Petitioners' claims. As discussed more fully above, Sheriff Callahan cannot be held liable in his individual capacity absent a showing that he acted with deliberate indifference. In order to meet this stringent standard of fault, there must be evidence that Sheriff Callahan disregarded a known or obvious consequence of his action. *See Bd. of Cnty. Comm'rs of Bryan Cnty., Okla.*, 520 U.S. 397, 410, 117 S. Ct. 1382, 1391. Specifically, there must be evidence that Sheriff Callahan knew about some objectionable conduct, facilitated it, approved it, condoned it, or turned a blind eye toward it for fear of what he might have discovered. *Gonzalez*, 996 F.2d at 761. In order for Sheriff Callahan to not be shielded by qualified immunity, the need for more or different training must have been "so obvious and obviously likely to result in a constitutional violation" that the failure to train amounted to deliberate indifference. *Id.* Such evidence does not exist in the present case. The Record contains no indication that Sheriff Callahan engaged in any conduct the recklessness of which would deprive him of the defense of qualified immunity. On the contrary, the record clearly shows that Sheriff Callahan's actions were objectively reasonable and did not meet the "extremely high" threshold of deliberate indifference. *See Gobert*, 463 F.3d at 346. The record shows that Sheriff Callahan advised the nurses regarding Dr. Bolin's behavior, instructed them to contact Dr. Bolin whenever they deemed it necessary, and instituted a policy of sending ill persons to the hospital. (USCA5, p.3051-3053.) Additionally, the Record shows that Sheriff Callahan counseled Dr. Bolin to improve his attitude toward the

nurses. (USCA5,Vol. 11, p. 2535.) The presence of these measures undermines any argument Sheriff Callahan exercised deliberate indifference with respect to the training and/or supervision of Dr. Bolin or the nurses. This undisputed evidence shows that Sheriff Callahan did not facilitate, approve, or turn a blind eye toward any conduct which would have violated Brown's constitutional rights. This untroverted evidence shows that Sheriff Callahan did not fail to supervise Dr. Bolin or the nurses, but rather acted as a mediator between him and Dr. Bolin's nursing staff.

In sum, the record shows that Sheriff Callahan's actions with respect to the facts underlying the present litigation did not meet the extremely high standard of deliberate indifference by disregarding a known or obvious consequence of his actions. Clearly, the record shows that none of Sheriff Callahan's actions in the present case could possibly meet this high standard with respect to his training and/or supervision of Dr. Bolin or the nurses. There is no evidence in the Record which would show that Sheriff Callahan knew of any objectionable conduct, facilitated it, approved it, condoned it, or turned a blind eye toward it for fear of what he might have discovered. *See Gonzalez*, 996 F.2d at 761. Therefore, the Fifth Circuit did not err in finding that Sheriff Callahan is entitled to qualified immunity. Sheriff Callahan respectfully requests that the Court refuse to grant the present Petition for Writ of Certiorari.

C. The Record plainly shows that Sheriff Callahan's actions did not meet the extremely high standard of deliberate indifference with respect to his adoption of policies.

In order to state a claim pursuant to § 1983 against an official in his individual capacity for failure to promulgate a policy, "the failure must be an 'intentional choice' and amount to subjective deliberate indifference." *Brumfield v. Hollins*, 551 F.3d 322, 328 (5th Cir. 2008) (quoting *Rhyne v. Henderson Cnty.*, 973 F.2d 386, 392 (5th Cir. 1992)). "In other words, it must be 'obvious that the likely consequence of not adopting a policy will be a deprivation of civil rights.'" *Id.* (quoting *Evans v. City of Marlin*, 986 F.2d 104, 108 (5th Cir. 1993)).

"In addition to culpability, there must be a direct causal link between the municipal policy and the constitutional deprivation. *Monell* describes the high threshold of proof by stating that the policy must be the 'moving force' behind the violation." *Pitrowski v. City of Houston*, 237 F.2d 567, 579 (5th Cir. 2001) (citations omitted) (emphasis added). The Court in *Pitrowski* holds that § 1983 plaintiffs must establish both the causal link and deliberate indifference to federal protected rights so that "where a court fails to adhere to rigorous requirements of culpability and causation, municipal liability collapses into 'respondeat superior liability.'" *Id.*

Here, the Record contains absolutely no evidence which would show that any actions of Sheriff Callahan caused any inmate—including Brown—to have their serious medical needs treated with deliberate

indifference. On the contrary, the Record shows that it was the custom of nurses in the Jail to take inmates to the hospital regardless of whether they believed that Dr. Bolin would have approved hospitalization for the inmate. Indeed, two former nurses testified that they had sent inmates to the hospital when they believed it to be necessary without regard to Dr. Bolin's opinions. (USCA5, Vol 11, J. App. 559,-562; 563-566.) Further, the Record shows that Sheriff Callahan instructed nurses to call Dr. Bolin whenever they needed him and he had drafted a policy which required acutely ill inmates to be transported to the hospital. (USCA5, Vol. 11, pp. 2438, 2510.) The actual policies Sheriff Callahan adopted encouraged nurses to take ill persons to the hospital. There is simply no causal connection between any policy Sheriff Callahan adopted and the events of which Petitioners complain. Therefore, Sheriff Callahan respectfully requests that the Court deny the present Petition for Writ of Certiorari.

CONCLUSION

WHEREFORE, PREMISES CONSIDERED, Respondent Sheriff Thomas Callahan respectfully requests that the Court deny the present Petition for Writ of Certiorari, and for any and all other relief, at law or in equity, to which he has shown himself to be justly entitled.

Respectfully Submitted,

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